E·N·T of ATHENS

RELEASE OF PROTECTED HEALTH INFORMATION

Authorization for Release: By signing below, I am authorizing the practice to disclose my Protected Health Information (PHI) about my current health condition to the following:

❑ Spouse ❑ Parents ❑ Children ❑ Grandparents

❑ Other (list names) ____

Authorization to Leave Messages: You may leave messages containing my medical information at the following phone number(s) without speaking to a person:

____________________ ____________________ ____________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been made aware of ENT of Athens' Notice of Privacy Practices and acknowledge it is posted in the waiting room, available on the website (entofathens.com) and I may request a paper copy of the privacy notice at this location. I understand that I may address any questions or concerns I may have about the Notice to the Practice's Compliance Officer.

______________________________ Signature of Patient

______________________________ Signature of Guardian or Representative (If executing on behalf of the patient)

______________________________ Patient's Printed Name

______________________________ Guardian / Representative's Printed Name

PATIENT PORTAL ACCESS TO MEDICAL RECORDS

ENT of Athens allows you to access your medical information through our Patient Portal. There you can update your demographics, access your medical records and communicate with your physician. If you would like to have access to your Patient Portal, we will send an evite to the email address below. Once you receive the evite click on the link and follow the instructions.

email address: ____